

Michigan Department of Community Health  
**Board of Chiropractic**  
P.O. Box 30670  
Lansing, Michigan 48909  
(517) 335-0918

## **CHIROPRACTIC EDUCATIONAL LIMITED LICENSURE INSTRUCTIONS**

Authority: P.A. 368 of 1978, as amended  
This form is for information only.

**NOTE:** It is your responsibility to have all required documentation sent to the Board of Chiropractic. Questions regarding your application can be directed to the Michigan Board of Chiropractic at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time. Applications submitted without the required licensing fee, applicant's signature and date will be returned.

The Educational Limited License can be issued only for the purpose of supervised practice as a part of your chiropractic education.

### **EDUCATIONAL LIMITED LICENSE APPLICANTS MUST SUBMIT THE FOLLOWING:**

1. A completed application and a check or money order, drawn on a U.S. financial institution, in the amount of \$50.00, made payable to the **STATE OF MICHIGAN**. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid. An Educational Limited license is valid for 6 months, with no extensions available. Please be sure to indicate the beginning date for the Education Limited License on the application where indicated.
2. Certification of chiropractic education submitted directly from the chiropractic school to the Board on the proper form (attached). You must have successfully completed at least two years, four semesters or six-quarter terms in an approved chiropractic school to be eligible for this license.
3. The completed Supervision Confirmation Form (attached) submitted directly to the Board by the supervisor of your educational training.
4. If you have ever held a permanent chiropractic license in another state, official verification of your license must be received in this office directly from the other state(s). You may use the Verification form that is attached to this application. Most states charge a fee for providing license verification.

### **GENERAL INFORMATION**

1. **NAME AND/OR ADDRESS CHANGES:** If your name and/or address changes please notify the Board of Chiropractic in writing. To change a name or address, you can download the [Data Change/Duplicate License Request Form](#) from our website [www.michigan.gov/healthlicense](http://www.michigan.gov/healthlicense) and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.
2. **REFUND POLICY:** If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Chiropractic in writing to request a refund.

## APPLICATION FOR EDUCATIONAL LIMITED LICENSE

Authority: Public Act 368 of 1978, as amended  
If this form is not completed, a license will not be issued.

### Type or Print Only

### Board Use Only

#### I AM APPLYING FOR THE FOLLOWING:

☐ Educational Limited License Fee: \$50.00 71-2301-05

License Number

Date of Licensure

**Start Date for Educational Limited License:** \_\_\_\_\_  
month, date, year

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application.  
**DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Michigan Permanent I.D. Number and Expiration Date
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	
Have you ever held a health professional license in Michigan? <input type="checkbox"/> No <input type="checkbox"/> Yes		

**Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.**

1. Have you ever been convicted of a felony?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you been treated for substance abuse in the past 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name
------

5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period? ☐ Yes ☐ No
6. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period? ☐ Yes ☐ No
7. Have you ever had a federal or state health professional license or registration revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you? ☐ Yes ☐ No
8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? ☐ Yes ☐ No
9. Do you hold or have you ever held a chiropractic license in any state? If so, list each state, the license number, the date issued, and how the license was obtained (either endorsement or examination). DO NOT LIST TEMPORARY LICENSES. **You must have each state board verify licensure directly to this board office. (Attach additional sheets necessary.)** ☐ Yes ☐ No

State	License/Registration Number	Date of Issue	How obtained (Endorsement or examination)

### CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date
------------------------	------

Michigan Department of Community Health  
**Board of Chiropractic**  
P.O. Box 30670  
Lansing, MI 48909  
(517) 335-0918

**SUPERVISION CONFIRMATION FORM FOR EDUCATIONAL LIMITED LICENSE**

Authority: Public Act 368 of 1978, as amended.  
If this form is not completed, certification will not be issued.

**PART I -APPLICANT INFORMATION:**

Instructions: Complete Part 1: Type or print your name exactly as it appears on your application. Send this form to your supervisor for completion of Parts II and III. This form must be submitted directly to the Board of Chiropractic from your supervisor.

First Name	Middle Name	Last Name	
Address		City	Zip Code
U.S. Social Security Number		Birth Date	

**PART II - SUPERVISOR INFORMATION**

Instructions: Please complete Part I, II, and III of this form and then mail it directly to the Board at the address given above.

Name	Michigan Permanent I.D. Number and Expiration Date
Current Business Address	
Current Position	

**PART III- CERTIFICATION OF SUPERVISION**

I hereby certify that I am a licensed chiropractor in the state of Michigan and will supervise	
_____ during the practice portion of	
Applicant's Full Name	
his or her chiropractic education. My direct supervision will conform with all existing laws and rules governing such supervision.	
_____	_____
Signature of Supervisor	Date
_____	
Print Name and Title of Supervisor	

Michigan Department of Community Health  
**Board of Chiropractic**  
P.O. Box 30192  
Lansing, MI 48909  
(517) 335-0918

**CERTIFICATION OF CHIROPRACTIC EDUCATION**

Authority: Public Act 368 of 1978, as amended  
If this form is not completed, a license will not be issued.

**SECTION I - APPLICANT INFORMATION**

**Instructions:** Applicant complete Section I. Type or print your name exactly as it appears on your application. Send this form to be completed and mailed directly to the board by the dean or registrar of the chiropractic school you attended for completion of Section II. This certification must be submitted directly to the Michigan Board of Chiropractic by the chiropractic school.

First Name	Middle Name	Last Name
Social Security Number	Date of Birth	
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	

Signature of Applicant	Date
------------------------	------

**APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DEAN OR REGISTRAR OF YOUR CHIROPRACTIC SCHOOL FOR COMPLETION OF SECTION II.**

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name
------

**THIS SIDE TO BE COMPLETED BY THE DEAN OR REGISTRAR OF THE CHIROPRACTIC SCHOOL**

**SECTION II - CERTIFICATION OF CHIROPRACTIC EDUCATION**

Instructions: Please complete the following information. Return this completed certification directly to the Michigan Board of Chiropractic at the address shown on the reverse side of this form.

Name of Chiropractic School				
Street Address of Chiropractic School				
City, State and ZIP Code				
<p>I certify that _____ has successfully completed at least (Applicant's Name)</p> <p>two years, four semesters, or six quarter terms in the chiropractic school named above.</p> <table style="width: 100%;"><tr><td style="width: 50%; text-align: center;">_____ Signature of Dean or Registrar</td><td style="width: 50%; text-align: center;">_____ Date of Signature</td></tr><tr><td style="text-align: center;">_____ Print or Type Name of Dean or Registrar</td><td style="text-align: center;"><p><b>(S E A L)</b></p><p>If school has no seal, please indicate</p></td></tr></table>	_____ Signature of Dean or Registrar	_____ Date of Signature	_____ Print or Type Name of Dean or Registrar	<p><b>(S E A L)</b></p> <p>If school has no seal, please indicate</p>
_____ Signature of Dean or Registrar	_____ Date of Signature			
_____ Print or Type Name of Dean or Registrar	<p><b>(S E A L)</b></p> <p>If school has no seal, please indicate</p>			